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	17E181	A. BUILDING _____ B. WING _____	C 03/06/2013

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CITIZENS MEDICAL CENTER LTCU	1625 S FRANKLIN AVE COLBY, KS 67701

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F 000	INITIAL COMMENTS The following citations represent the findings of a partial extended survey for investigation of complaints #64026 and #63191.	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: The facility had a census of 56 residents. The sample included 3 current residents and 1 former resident. Each sampled resident experienced significant changes in their medical conditions which necessitated transport to the hospital. Based on observation, interview and record review, the facility failed to immediately notify the residents' physician of significant changes in the residents' physical conditions (deterioration in level of consciousness and/or deteriorations in respiratory status) for 2 of 4 sampled residents. (Residents #1, #2) Findings included: - Resident #1's clinical record included a 12/2/12 Quarterly MDS (Minimum Data Set) which identified the resident with a moderate cognitive impairment, the need for extensive assistance of one staff for transfers, the ability to walk with assistance of one staff, use of a walker and wheelchair, unsteady balance in all areas, no functional limitations in range of motion, and no falls since admission to the facility. The 12/11/12 care plan noted resident #1's risk for falls related to daily use of antipsychotic medication. The care plan also noted the resident's "altered thought processes related to short term memory problems and hallucinations." Interdisciplinary Progress Notes written on Sunday, 1/13/13 at 10:30 p.m. described resident #1's fall from a standing position to the floor at	F 157		

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approximately 4:55 p.m., with the resident's head striking the floor during the fall. According to the notes, resident #1 immediately complained of pain on the back of his/her head. The nurse who wrote the entry into the notes described a "swollen area to the back of the head." The resident did not experience other injuries during the fall. The nurse notified resident #1's family of the fall and, "message left for [name of ARNP/advanced registered nurse practitioner C]..."

Additional Interdisciplinary Progress Notes included the following:

o 1/16/13 at 8:00 a.m.: "Message left for [ARNP C]....This a.m. when CNA [certified nurse aide] went to get resident up, resident not acting like [him/herself]. Residents temperature 101.2 axillary [under the arm]. Resident also has emesis X 1 this a.m.....Resident in recliner in room with eyes closed."

o 1/16/13 at 9:40 a.m. (written by nursing student): "Resident hard to wake up....temperature 101.2 axillary....emesis is yellow fluid.....breathing is shallow....."

o 1/16/13 at 11:40 a.m.: "Message left for [ARNP C] on cell phone to call facility. Resident O2 [oxygen] sat [saturation] dropping under 90%....continues to be drowsy and lethargic....Will continue to monitor. Also message left at [name of medical clinic] for [ARNP C]."

o 1/16/13 at 3:15 p.m.: "Call to [clinic], message left for [ARNP C]. Call then to [ARNP C] on cell number....New phone order...Resident with

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sternal rub and unresponsive. Neuros, no hand grasp, resident unarousable....new order to transport resident to [hospital]."

The clinical record included no evidence ARNP C returned the calls or responded to messages left by the charge nurse on 1/16/13 in the 7 hour time period between 8:00 a.m. and 3:15 p.m.. The clinical record also included no evidence facility staff attempted to contact resident #1's physician when ARNP C failed to respond to phone calls/messages.

A 1/16/13 "History and Physical" from the hospital included, "...Patient presents to the emergency room.....sustained a fall on Sunday....For most of the day [his/her] level of consciousness has decreased and [he/she] has been hypoxic [decreased oxygen levels] at the nursing home....Difficult to assess due to decreased level of consciousness....CT [computerized tomography] of head shows acute subdural hematoma and acute subarachnoid hemorrhage....visited with family who want comfort care....will admit and monitor."

The U.S. National Institutes of Health website http://nim.nih.gov gives the following definitions:

o Subdural hematoma: a collection of blood on the surface of the brain....may occur after a very minor head injury, especially in the elderly...may go unnoticed for days to weeks. Symptoms include headache, lethargy or confusion, loss of consciousness and nausea and vomiting.

o Subarachnoid hemorrhage: bleeding the area between the brain and the thin tissues that cover

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the brain....often seen in the elderly who have fallen and hit their head....Symptoms include a severe headache, decreased consciousness and alertness, nausea and vomiting.

A 1/19/13 "Discharge Summary" from the hospital noted resident #1's death at 7:00 a.m. on that date.

During an interview on 2/27/13 at 10:55 a.m., Licensed Nurse B reported he/she worked from 6 a.m. - 2 p.m. on 1/16/13, the date resident #1's condition deteriorated noticeably. According to Nurse B, at about 8:00 a.m., the CNA reported that resident #1, "wasn't acting right" and seemed drowsy. After assessing the resident, Nurse B attempted to call the ARNP but did not get a response. Nurse B then called the clinic and left a message on the nurse's voice mail. Nurse B recalled that he/she attempted to contact the ARNP at least one other time during the shift, but the ARNP did not return the calls. According to Nurse B, he/she did not know what to do when the ARNP failed to return the calls. Nurse B confirmed he/she did not attempt to contact resident #1's physician or any other physician to report the change in condition. Nurse B confirmed the ARNP failed to return the phone call or respond to the messages by the time the shift ended at 2:00 p.m..

During an interview on 2/26/13 at 5:07 p.m., Licensed Nurse D confirmed he/she worked the afternoon of 1/16/13 when resident #1 required transfer to the hospital. According to Nurse D, during the end of shift report the day charge nurse reported resident #1 had emesis and

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decreased level of consciousness and that ARNP C failed to return calls/messages throughout the day shift. Nurse D reported he/she assessed resident #1 immediately after report ended, and found the resident unresponsive to a sternal rub and without the ability to grasp with his/her hands as part of the neurological checks required. According to Nurse D, he/she first called the clinic and left ARNP C a message on a voice mail and then, after reviewing the chart and noting the length of time since the day nurse first tried to reach ARNP, decided to just call ARNP C's cell phone directly. After Nurse D described resident #1's condition, ARNP C ordered transfer to the hospital emergency room for evaluation. Licensed Nurse D also denied knowledge of what to do if a physician or mid-level practitioner failed to return phone calls or messages in a timely manner.

During an interview on 2/27/13 at 11:10 a.m., ARNP C reported he/she examined resident #1 on 1/14/13, the day after the fall where the resident struck his/her head on the floor. At the time of that examination, resident #1 had a bump on the back of the head as well as some tenderness in that area, but "remained as normal as I've ever seen [him/her]." ARNP also confirmed he/she was on call for residents at the facility on 1/16/13 and therefore responsible for responding to telephone calls and/or messages related to resident health issues/concerns. ARNP C reported he/she did not recall receiving any messages or phone calls from the facility on the morning of 1/16/13, and in fact knew nothing about the deterioration in resident #1's condition until Licensed Nurse D called him/her mid-afternoon on that day. After learning of resident #1's altered level of consciousness and

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other physical symptoms, ARNP C reported he/she ordered immediate transfer to the hospital emergency room. According to ARNP C, if he/she had known about the changes Nurse B saw at 8:00 a.m. on the morning of 1/16/13, he/she would have ordered transfer to the hospital at that time. ARNP C reported all nursing staff at the facility know they should call his/her cell number immediately if there is a need for immediate response, and if they can't reach him/her on the cell phone, they should call one of the physicians.

According to the facility's undated "Physician Services" policy, "In the event the attending physician is not available, the charge nurse on duty will call the on-call physician....".

According to the facility's undated "Neurological Checkpoints, Monitoring" policy, staff should "Report significant changes in neurological response to physician immediately."

The facility failed to immediately notify the physician/ARNP of significant changes in resident #1's physical condition. The facility also failed to follow up with resident #1's physician or an alternate physician when ARNP C failed to return calls/messages over a 7 hour time period. Resident #1's condition deteriorated significantly during the 7 hour time period.

- Resident #2's clinical record included a 2/18/13 Significant Change MDS (Minimum Data Set) which identified the resident with no cognitive impairment.

CAAs (Care Area Assessments) completed on 2/18/13 included, "Resident hospitalized on

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1/24/13 with diagnosis of respiratory failure....resident was intubated and placed in ICU [intensive care unit] until [he/she] was able to be moved to the main floor."

The undated care plan included interventions related to resident #2's respiratory diagnoses and medications/interventions used to treat those conditions.

Interdisciplinary Progress Notes included the following:

o 1/21/13 at 10:10 a.m.: "This nurse reviewed VS [vital signs on chart. This nurse noted resident's O2 [oxygen] sat [saturation] at 85%.....CNA [certified nurse aide] also reports resident has had no urine output this a.m.. O2 sat rechecked - 91%. Message left for [ARNP C] to notify of resident's condition....".

o 1/21/13 at 12:55 p.m.: "Lung sounds no wheezes in bilateral lower lobes. A squeak sound in upper right lobe. Resident continue to c/o [complain of] SOA [short or air]. Resident does not come out of room this shift. Resident does void X 1 this shift."

o 1/21/13 at 1:50 p.m.: "Message left for [ARNP C] at [clinic] to notify [him/her] of lung sounds.

o 1/21/13 at 4:50 p.m.: "[ARNP C] called facility at this time with new orders.... Resident continues to c/o SOA, O2 sat 85% on 2L (2 liters of oxygen). Will continue to monitor."

The clinical record included no evidence ARNP C responded to the message about resident #2's

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condition in the 3 hour time period between 1:50 p.m. and 4:50 p.m.. The clinical record also include no evidence the charge nurse attempted to notify resident #2's physician or an alternate physician when ARNP C failed to respond to the message.

Additional Interdisciplinary Progress Notes included:

o 1/24/13 at 10:30 a.m.: This entry indicated a licensed nurse left a message for ARNP C at 6:30 a.m. requesting a chest Xray due to resident #2's continued complaints of shortness of air and O2 saturation rate of 90% on 3 liters of oxygen, and as of 10:30 a.m. there had been no response from ARNP C. The licensed nurse described resident #2's condition as of 10:30 a.m. as, "lungs with upper airway wheezes...posteriorly no breath sounds auscultated. Resident voice weak...." Immediately after that entry the nurse got in contact with ARNP C who ordered staff to transfer resident #2 to the hospital emergency room.

According to notes from the hospital, resident #2 received an initial assessment in the emergency room and then was sent to a large hospital approximately 2.5 hours away for treatment of "respiratory failure."

Transfer documents indicated resident #2 returned to the facility on 2/12/13.

During an observation on 2/27/13 at 8:20 a.m., resident #2 sat in a recliner in his/her room with oxygen supplied via nasal cannula. The resident was alert and oriented. The resident could not

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recall the events leading up to the hospitalization on 1/24/13 other than stating, "It was so bad. I just remember I couldn't catch my breath."

During an interview on 2/27/13 at 10:55 a.m., Licensed Nurse B reported a lack of knowledge related to what nurses should do if a physician or mid-level practitioner failed to return phone calls or messages. Nurse B also reported he/she didn't know how long to wait before trying to get ahold of another physician, or if contacting another physician was allowed.

During an interview on 2/26/13 at 5:07 p.m., Licensed Nurse D denied knowledge of what to do if a physician or mid-level practitioner failed to return phone calls or messages in a timely manner.

During an interview on 2/27/13 at 11:10 a.m., ARNP C reported facility staff should know the protocol for contacting physicians and/or mid-level practitioners. According to ARNP C, "They should call me on my cell if it's an emergency and I respond immediately. If it's less urgent they can leave a message.... If for some reason I don't call them back they need to call the physician." ARNP C could not recall if staff left a message at the clinic at 6:30 a.m. on 1/24/13 related to resident #2's respiratory issues.

According to the facility's undated "Physician Services" policy, "In the event the attending physician is not available, the charge nurse on duty will call the on-call physician....".

The facility failed to immediately notify the physician/ARNP of significant changes in resident

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F 157	Continued From page 10 #2's physical condition. The facility also failed to follow up with resident #2's physician or an alternate physician when ARNP C failed to return calls/messages over a 4 hour time period.	F 157		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 56 residents. The sample included 3 current residents and 1 former resident. Based on observation, interview and record review, the facility failed to provide 1 of 4 sampled residents with the necessary care and services (ongoing nursing assessments of a resident with a significant change in his/her medical condition; failure to notify the physician of the changes in the medical condition) to maintain the resident's highest practicable physical well-being. Resident #1's physical condition deteriorated over a time period of 7 hours in which staff failed to complete adequate assessments and failed to notify the physician of changes in the medical condition. Facility failure to complete ongoing nursing assessments after a significant change in condition and failure to notify the physician of the changes delayed prompt medical intervention,	F 309		

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thereby placing resident #1in immediate jeopardy.

Findings included:

- Resident #1's clinical record included a 12/2/12 Quarterly MDS (Minimum Data Set) which identified the resident with a moderate cognitive impairment, the need for extensive assistance of one staff for transfers, the ability to walk with assistance of one staff, use of a walker and wheelchair, unsteady balance in all areas, no functional limitations in range of motion, and no falls since admission to the facility.

The 12/11/12 care plan noted resident #1's risk for falls related to daily use of antipsychotic medication. The care plan also noted the resident's "altered thought processes related to short term memory problems and hallucinations."

Interdisciplinary Progress Notes written on Sunday, 1/13/13 at 10:30 p.m. described resident #1's fall from a standing position to the floor at approximately 4:55 p.m., with the resident's head striking the floor during the fall. According to the notes, resident #1 immediately complained of pain on the back of his/her head. The nurse who wrote the entry into the notes described a "swollen area to the back of the head." The resident did not experience other injuries during the fall. The nurse notified resident #1's family of the fall and, "message left for [name of ARNP/advanced registered nurse practitioner C]..."

Review of Interdisciplinary Progress Notes, Neurological Flow Sheets and Vital Flow sheets

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for 1/14/13 and 1/15/13 included evidence of nursing assessment of resident #1's neurological status once per shift throughout the two day time period.

Additional Interdisciplinary Progress Notes included the following:

o 1/16/13 at 8:00 a.m.: "Message left for [ARNP C]....This a.m. when CNA [certified nurse aide] went to get resident up, resident not acting like [him/herself]. Residents temperature 101.2 axillary [under the arm]. Resident also has emesis X 1 this a.m.....Resident in recliner in room with eyes closed."

A "Neurological Assessment Flowsheet" completed on 1/16/13 at 8:00 a.m. noted a change in resident #1's level of consciousness from "alert" at the time of all previous assessments to "drowsy" at the time of this assessment.

The clinical record revealed no additional assessments of neurological status between the hours of 8:00 a.m. and 3:00 p.m. on 1/16/13.

o 1/16/13 at 9:40 a.m. (written by nursing student): "Resident hard to wake up....temperature 101.2 axillary....emesis is yellow fluid.....breathing is shallow....."

o 1/16/13 at 11:40 a.m.: "Message left for [ARNP C] on cell phone to call facility. Resident O2 [oxygen] sat [saturation] dropping under 90%....continues to be drowsy and lethargic....Will continue to monitor. Also message left at [name of medical clinic] for [ARNP C]."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 o 1/16/13 at 3:15 p.m.: "Call to [clinic], message left for [ARNP C]. Call then to [ARNP C] on cell number....New phone order...Resident with sternal rub and unresponsive. Neuros, no hand grasp, resident unarousable....new order to transport resident to [hospital]." Review of Interdisciplinary Progress Notes, Neurological Flow Sheets and Vital Flow sheets for 1/14/13 and 1/15/13 included evidence of nursing assessment of resident #1's neurological status once per shift throughout the two day time period. The resident's neurological status remained unchanged/within normal limits during that time period. Licensed Nurse B continued to assess resident #1's neurological status only once per shift even after the resident's condition deteriorated on 1/16/13. The clinical record contained no evidence of thorough nursing assessments between the hours of 11:40 a.m. and 3:15 p.m even though the resident, with a history of a recent fall with a blow to the head, experienced a change in his/her level of consciousness and started vomiting earlier that day. The clinical record also lacked evidence ARNP C returned the calls or responded to messages left by the charge nurse on 1/16/13 in the 7 hour time period between 8:00 a.m. and 3:15 p.m.. The clinical record included no evidence facility staff attempted to contact resident #1's physician when ARNP C failed to respond to phone calls/messages.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E181	A. BUILDING _____ B. WING _____	C 03/06/2013

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A 1/16/13 "History and Physical" from the hospital included, "...Patient presents to the emergency room.....sustained a fall on Sunday....For most of the day [his/her] level of consciousness has decreased and [he/she] has been hypoxic [decreased oxygen levels] at the nursing home....Difficult to assess due to decreased level of consciousness....CT [computerized tomography] of head shows acute subdural hematoma and acute subarachnoid hemorrhage....visited with family who want comfort care....will admit and monitor."

The U.S. National Institutes of Health website http://nim.nih.gov gives the following definitions:

o Subdural hematoma: a collection of blood on the surface of the brain....may occur after a very minor head injury, especially in the elderly...may go unnoticed for days to weeks. Symptoms include headache, lethargy or confusion, loss of consciousness and nausea and vomiting.

o Subarachnoid hemorrhage: bleeding the area between the brain and the thin tissues that cover the brain....often seen in the elderly who have fallen and hit their head....Symptoms include a severe headache, decreased consciousness and alertness, nausea and vomiting.

A 1/19/13 "Discharge Summary" from the hospital noted resident #1's death at 7:00 a.m. on that date.

During an interview on 2/27/13 at 10:55 a.m., Licensed Nurse B reported he/she worked from 6 a.m. - 2 p.m. on 1/16/13, the date resident #1's

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condition deteriorated noticeably. According to Nurse B, at about 8:00 a.m., the CNA reported that resident #1, "wasn't acting right" and seemed drowsy. After assessing the resident, Nurse B attempted to call the ARNP but did not get a response. Nurse B then called the clinic and left a message on the nurse's voice mail. Nurse B recalled that he/she attempted to contact the ARNP at least one other time during the shift, but the ARNP did not return the calls. Nurse B confirmed the ARNP failed to return the phone call or respond to the messages by the time the shift ended at 2:00 p.m.. Nurse B also confirmed licensed nurses complete neurological checks once per shift for 72 hours after falls. According to Nurse B, he/she completed the neuro check for resident #1 on 1/16/13 at 8:00 a.m. and noted a decreased level of consciousness. Nurse B confirmed he/she did not reassess resident #1's neurological status the remainder of the shift which ended at 2:00 p.m..

During an interview on 2/26/13 at 5:07 p.m., Licensed Nurse D confirmed he/she worked the afternoon of 1/16/13 when resident #1 required transfer to the hospital. According to Nurse D, during the end of shift report the day charge nurse reported resident #1 had emesis and decreased level of consciousness and that ARNP C failed to return calls/messages throughout the day shift. Nurse D reported he/she assessed resident #1 immediately after report ended, and found the resident unresponsive to a sternal rub and without the ability to grasp with his/her hands as part of the neurological checks required. According to Nurse D, he/she first called the clinic and left ARNP C a message on a voice mail and then, after reviewing the chart and noting the

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length of time since the day nurse first tried to reach ARNP, decided to just call ARNP C's cell phone directly. After Nurse D described resident #1's condition, ARNP C ordered transfer to the hospital emergency room for evaluation.

During an interview on 3/1/13 at 8:15 a.m., Administrative Nurse A reported he/she reviewed resident #1's clinical record after the resident went to the hospital on 1/16/13 and found a lack of adequate nursing assessments as well as nurse failure to contact the physician in a timely manner when ARNP failed to respond to calls/messages.

According to the facility's undated "Neurological Checkpoints, Monitoring" policy, "The frequency of neurological checks is determined by the degree of the resident's injury or illness and the stability of the neurological signs."

The facility failed to provide resident #1 with the necessary care and services (ongoing nursing assessments of a resident with a significant change in his/her medical condition; timely physician notification of changes in the medical condition) to maintain the resident's highest practicable physical well-being. Resident #1's physical condition deteriorated over a time period of 7 hours in which staff failed to complete adequate assessments and failed to ensure the physician knew of the changes in the resident's medical condition. Facility failure to complete ongoing nursing assessments after a significant change in condition and failure to notify the physician of the changes delayed prompt medical intervention, thereby placing resident #1in immediate jeopardy.

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F 309	Continued From page 17 The facility abated the immediate jeopardy on 3/6/13 at 1:30 PM when they developed and implemented the following measures: A protocol for when Licensed nurses should contact the mid level practitioners. A protocol to notify the Physician if they cannot contact the mid level practitioners. A protocol on how and when to do neurological assessments. A protocol on doing ongoing assessments on a resident that has had a change in condition All nursing staff were inserviced on these new protocols, inservices were completed on 03/06/13 at 1:30 PM This deficient practice remains at a scope/severity of a "G" .	F 309		